APPEALS

SECTION D

MEDICARE APPEAL PROCESS

Traditional Medicare Part A Appeals

A Traditional Medicare Part A appeal starts with a notice from the provider to the Medicare beneficiary that the provider does not believe Medicare coverage can continue past a specified date. The notice contains a form that the beneficiary may complete and return to the provider. By completing and returning the form, the beneficiary can indicate that she wants to continue the services (and will find a way to pay for them) and that she believes Medicare should continue to cover the service.

There are three levels of administrative appeal that an aggrieved Medicare beneficiary may pursue, followed by the option of filing a case in federal court. There are slight differences in the structure of the appeal process for hospital, skilled nursing facility and home health cases. The rules must be closely followed. All original documentation and copies of written appeals should stay in your possession.

Hospital Appeals

Important Message to Medicare Beneficiaries is given to the patient upon admission. The text of the Important Message may be found on Pages 7-8 of the Medicare Hospital Manual, Transmittal 801. This Transmittal can be viewed at http://www.cms.hhs.gov/medicare/bni/R193FormInstruction.pdf

The Medicare beneficiary/patient is informed that Medicare coverage for the hospital stay will cease.

I. Immediate Review

The patient may appeal by requesting an Immediate Review.

- To request an Immediate Review, the patient is informed by the Important Message to call 1-800-Medicare for referral to Quality Improvement Organization, (QIO). **In Indiana it is Health Care Excel.**

- The patient must call the QIO to ask for Immediate Review.
- The call to the QIO must be made by noon of the day after hospital notification that Medicare coverage will cease.
- The QIO obtains the pertinent hospital records, reviews them and makes a decision on Medicare coverage by the following day.
- The QIO decision is delivered in writing. If mailed, there is a presumption that it is received no later than 5 days after it was mailed.
- If the QIO affirms the Medicare coverage termination, the patient becomes liable for the cost of the care if she does not leave the hospital by noon of the day following receipt of the QIO's adverse Immediate Review decision.

II. Reconsideration

The beneficiary may appeal the QIO's adverse Immediate Review decision by requesting Reconsideration.

- Reconsideration must be requested in writing and request forms are available on http://www.medicare.gov/Basics/forms/default.asp.
- Reconsideration must be requested within 120 days of receipt of the Immediate Review decision. Reconsideration requests may be filed with the Social Security Administration, or with the QIO.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.
- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.
- There must be at least $1,220 at issue in order to appeal a Medicare denial of hospital coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There is no minimum amount to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $1,220 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Skilled Nursing Facility (SNF) Appeal

The SNF Notice: The SNF provides a written notice, called a Sarassat Notice. The Sarassat Notice informs the Medicare beneficiary that if they disagrees with the SNF's determination that Medicare coverage will cease, they must complete and return to the SNF the form included with the notice (usually found on the back of the notice,) indicating that they want the SNF to submit a claim to the Medicare fiscal intermediary for services provided after the date the Sarassat notice indicates that Medicare coverage will cease.

The Demand Bill

The claim submission is called a demand bill. Unless she remains in the SNF receiving daily skilled services, and has the SNF submit a demand bill, no Medicare appeal may be brought.

I. The Medicare Initial Determination

The Medicare fiscal intermediary reaches a decision on Medicare coverage and notifies the beneficiary by sending a Medicare Summary Notice, (MSN). To view Medicare Summary Notices and to obtain more information about these notices, go to http://www.medicare.gov/Basics/SummaryNotice.asp.

II. Reconsideration

The beneficiary must request Reconsideration in writing no later than 120 days after receipt of the adverse MSN. Reconsideration must be requested in writing and request forms are available on http://www.medicare.gov/Basics/forms/default.asp.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.

- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.

There must be at least $120 at issue in order to appeal a Medicare denial of hospital coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There is no minimum to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $1,220 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Home Health Care

The Home Health Agency Notice

At least one day or one visit prior to the discontinuance of Medicare coverage, the home health agency gives the patient a **Home Health Advance Beneficiary Notice, (called a HHABN)** . The HHABN contains a form that must be complete returned to the home health agency, to request submission of a demand bill.

Requirements to Maintain a Home Health Appeal

In order to maintain a Medicare appeal, services must be continued after the date on which the agency has notified the beneficiary that Medicare coverage will cease, and a demand bill must be submitted to the Medicare fiscal intermediary or carrier (depending upon which Part of Medicare was covering the services prior to the issuance of the HHABN).

I. The Medicare Initial Determination

The Medicare carrier or fiscal intermediary makes a decision and transmits it to the beneficiary by issuing an MSN. Medicare decisions based on demand and bills are usually adverse to the beneficiary, ratifying the provider's view that Medicare coverage should cease.

II. The Reconsideration

The beneficiary must request Reconsideration in writing no later than 120 days after receipt of the adverse MSN.

- Reconsideration must be requested in writing and the request forms are available on http://www.medicare.gov/Basics/forms/default.asp.
- Reconsideration must be requested within 120 days of receipt of the Immediate Review decision. Reconsideration requests may be filed with the Social Security Administration, or with the fiscal intermediary.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing. The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision. The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp. There must be at least $120 at issue in order to appeal a Medicare denial of home health coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There is no minimum to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There 1,220 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision. While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Traditional Medicare Part B Appeals

In Medicare Part B, the provider always submits the Medicare claim to the Medicare carrier. The Medicare Carrier issues its initial determination in a notice to the beneficiary, after which, an aggrieved beneficiary may pursue three levels of administrative review, followed by the possibility of filing a federal court case. The rules governing the time lines for submission of appeals and the amount of money that must be at issue must be closely followed.

I. The Medicare Claim

The Medicare Part B provider submits the Medicare claim to the carrier.

II. The Initial Determination

The carrier makes a decision on Medicare coverage, called an initial determination. The Medicare carrier sends the Initial Determination to the beneficiary by issuing an MSN or an Explanation of Medicare Benefits, (EOMB.) To view Medicare Summary Notices and to obtain more information about these notices, you may go to http://www.medicare.gov/Basics/SummaryNotice.asp.

III. The Review

An adverse initial determination is appealed by requesting a review by the carrier. A request for review must be made in writing and forms for this purpose may be found on http://www.medicare.gov/Basics/forms/default.asp.

The review request must be filed with the carrier by 120 days after receipt of the MSN or EOMB. There is a 5 day presumption for receipt after the date on which the carrier mailed the MSN or EOMB to the beneficiary.

IV. The Carrier Hearing

If the review decision is adverse, the beneficiary may appeal by requesting a Carrier Hearing.

- The Carrier Hearing must be requested within 180 days of receipt of the adverse review decision.
- There must be $100 at issue to take an appeal to a Carrier Hearing.
- The Carrier Hearing must be requested in writing and forms for requesting a Carrier Hearing may be found on http://www.medicare.gov/Basics/forms/default.asp.

V. The Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.
- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.
- There must be at least $120 at issue in order to appeal a Medicare Part B overage denial to an Administrative Law Judge.

VI. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal.

- DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at www.medicare.gov.
- There is no minimum to appeal a case to the DAB.

VII. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $1,220 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.